ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: July 13, 2018 Case Number: 19-03

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: N Valley Pet Hospital (William R Dean)
Premise Name: N. Valley Pet Hospital
Premise Address: 440 E. Hammer Ln
City: Prescott State: AZ Zip Code: 86303
Telephone: (928) 768-8387

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Daniella J. Hart
Address: [redacted]
City [redacted] State: [redacted] Zip Code: [redacted]
Home Telephone: _____ Cell Telephone [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
JUL 13 2018
BY:

C. **PATIENT INFORMATION (1):**

Name: Karma

Breed/Species: Lab mix

Age: Appx 1 1/2 Sex: F Color: Tri

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

N. Valley Pet Hospital
1440 E. Hammer Rd
Fort Mohave, Az. 86426
(928) 768-8387

Nova Animal Care Center
332 London Bridge Rd
Lake Havasu City, Az. 86403
(928) 855-0588

VCA Animal Specialty Group
4624 Colorado Blvd (818)
Los Angeles, Ca 90039 244-1977

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: July 10, 2018

*See attached documentation.

On April 26, 2017: Karma was seen at Novak Animal Care Center for a wellness exam.

Sept 22, 2017: Novak examined Karma after she had fallen while playing ball. Shad some limping on her right leg.

Sept 30, 2017: I returned to Novak with Karma and was told she needed to be X-rayed and was not able to pay the fees.

Oct. 2, 2017, Karma was moved to N Valley Animal Clinic. Records were transferred from Novak Animal Care Center.

On her initial visit she was examined by Katherine Goulbourn. She stated that it may be an ACL issue.

Nov. 2, 2017, I meet with William Dean and he examined Karma. He stated it that it may be an ACL issue.

Dec. 5, 2017: Karma was taken to N Valley Animal Clinic for her ACL surgery. Surgery was not performed due to it was uncovered that she had hip dysplasia

In the records you will find a copy of a canine emergency form and a Admission information to consent to surgery, which contains a fraudulent signature.

Jan. 2, 2018: Dr. Dean examined Karma and we discussed her upcoming hip dysplasia surgery. I asked him if he would be willing to provide her aftercare and he agreed.

Feb. 2, 2018: Dr. Dean examined Karma and cleared her for her surgery to be performed in California.

Feb. 7, 2018: Karma was taken to VCA Animal Specialty Group in California and was admitted for her surgery. (See att. Documentation)

Feb. 27, 2018: At 2:00 p.m., Karma returned to Dr. Dean's clinic for her stitch removal. Dr. Dean stated that her surgery stitches were not there. As we exited the exam room, Karma began slipping and sliding and fell by the weigh scale. Jennie took her leash and placed her in carpeted area, to prevent her from falling, while I went to the restroom.

Upon arrival at clinic, there was an employee mopping the floor in hallway by entrance to waiting room area.

Feb. 28, 2018: I contacted Dr. Dean's office and spoke to an employee that her stiches were still present and that she had been limping, due to fall. The employee spoke with Dr. Dean and scheduled an appointment for Mar 1, 2018 and asked if she had fallen at home, to where I stated she had fallen at the clinic.

Mar. 1, 2018: We returned to the clinic and an employee took Karma to the back area to remove stitches. Karma was returned to me and I asked if all stiches had been removed and was told that they had been. I questioned about a stich on top and was told it was "scar tissue".

As we were checking out, I requested that she be x-rayed due to the fall that occurred in the clinic.

I was never notified by Katherine Goulbourn regarding her X-rays. I contacted the clinic later that afternoon and was told she was out on a house call.

I then contacted VCA Animal Specialty Group, due to not receiving a call back from N Valley Animal clinic. They contacted N Valley Animal Clinic and requested their records.

The office manager from N Valley Animal Clinic had left me a voicemail in regards to an overcharge on her x-rays. I had been charged for two when only one had been taken.

Animal Speciality Group called me back and stated they had spoken to their doctor and that Karma was to be placed on restriction, due to I was not able to get her to California.

March 2, 2018: Dr Dean contacted me and stated Karma had a sprain. We spoke in regards to her fall that occurred at the clinic and I asked him to check his security cameras. He agreed to refund the cost of the x-rays and that his office manager would contact me.

A little while later, his office manager contacted me and requested my Care Credit information to refund the x-ray fee.

I received a partial refund of $ 93.11 in the mail.

On Mar. 27, 2018 3:40: Karma returned to N Valley Animal Hospital and was examined by Dr. dean and we agreed to begin her physical therapy at the clinic. While waiting in the waiting room, I observed two kittens in a window display. A black and white kitten appeared to have an anal gland impact. I inquired with the staff that there was something wrong with that particular kitten. Both kittens were up for adoption. The second portion of refund was returned of $40.19 after invoice verified.

On April 4, 2018: Karma began her first physical therapy treatment and we signed in. The kittens had been returned to the window display and the black and white kitten had been shaved. I also observed that Dr. Dean's security cameras had been moved, closer to center area of office area.

April 6, 2018 3:10: Karma completed her physical therapy and when exiting exam room, she almost fell due to employee spraying Lysol outside of door of exam room.

April 9, 2018 3:10: Karma had a 10:50 appointment which had been cancelled.

April 11, 2018 9:20: Karma was taken to her PT session and I was asked to stay out for a private assessment. When she was returned to me the employee had stated that Dr. Dean said that she had a 10% improvement in her range of motion and a 50-60 percent in walking. I asked the employee for a clarification and one was not provided.

It was during this visit that upon arrival, that her behavior was odd. The employee and I discussed animal behavior.

April 17, 2018 2:10: Karma's physical therapy had been cancelled for that week.

April 25, 2018 10:40: Dr. Dean was in the exam room, when we arrived and inquired as to how Karma was doing. I stated that she been doing better and we discussed her behavior.

May 2, 2018 10:10: appointment was cancelled.

May 4, 2018: I confirmed appointment with Dr. Dean's staff and requested to meet with him.

May 5, 2018: Karma completed her physical therapy and I stated to Jesse that her vaccine was due. Jesse left and went to contact Dr. Dean.

Dr. Dean entered the room and we discussed ending her physical therapy, due to my concern of her surgery being delayed. I inquired about her vaccine and was told that Jesse was preparing it. Dr. Dean left the room and Jesse administered the vaccine into her hip area.

June 6, 2018, I contacted Kristin and scheduled an appointment for her lab work and genetics.

June 8, 2018: I rescheduled the appointment for June 12, 2018.

June 12, 2018: I cancelled the appointment due to a ~~person~~ reminder doctor appointment and we rescheduled for June 20, 1018.

On June 13, 2018, I picked up a copy of Karma's vaccine records (Reminder Status Report) and confirmed appointment for June 20, 2018.

On June 20, 2018 we arrived for Karma's appointment and was told she did not have an appointment and that she could be scheduled in. The office staff inquired as to what type of appointment had been scheduled and I stated lab work and genetics and possibly chest x-ray for clearance of California surgery. California surgery had been scheduled for June 27, 2018.

Karma's surgery was cancelled due to personal issues and is to be scheduled at a later date.

Dr. Williams Dean's records reflect several inconsistences in regards to dates, weight and medications dispensed and feeding information.

There was never any type of canine emergency.

I have reason to believe there may be a programing problem at the clinic, due to Karma's appointment of June 20, 2018 not reflecting.

In addition, I removed the last remaining stich, in April 2018.
exhib #1 (photo showing stich) Circle indicates the stick I removed
exhib #2 (photo of surgery stich)

I

North Valley Pet Hospital
1440 East Hammer Rd., Fort Mohave, AZ 86426
Call: 928.768.8387
Fax: 928.768.2106
Visit: NorthValleyPet.com

7/21/2018

Arizona State Veterinary Medical Examining Board
1740 W. Adams St., Ste 4600
Phoenix, AZ 85007

19-03 in Re: William Dean, D.V.M.

To Whom It May Concern:

Thank you for allowing me to express my position in respect to the complaints made by Ms. Hart. From my reading of her complaint, I do not understand what her main complaint is. Rather, it seems like a series of complaints based upon her misinterpretation of the medical records she was sent on June 22, 2018 and half truths that she has put forth. Some that I was aware of prior to reading this complaint, and some that are new to me in this complaint. Since I feel there is no complaint overall, I will address each of her statements individually.

Karma was initially examined by Dr. Kate Goulbourn and I had no contact with Karma or Ms. Hart until December 5, 2017 when Karma presented to me for cranial cruciate ligament repair. I did not meet with Ms. Hart on November 2 as she indicates. I was not even in the office on November 2 as Thursdays are typically my day off.

On December 5, 2017, Karma was presented in the morning and I checked her in for surgery. I did her pre-surgical examination in the room with the owner present and found there to be Grade 2 of 5 lameness present in the left rear limb and an abnormal pelvic limb conformation. I presented the estimate for surgery and explained the admission information and consent to surgery which she signed digitally in my presence on our signature pad. The signature in the records she was sent is small and may be a reason why she suspects forgery, however the signature in the digital record is very similar to the signature on the complaint investigation form. Karma was then sedated and I was able to do an in-depth examination of her stifles and hips. I did not find any cranial drawer sign or tibial thrust in either stifle. There was positive ortolani sign in both hips. Radiographs were taken of the pelvis and both stifles. There was severe hip dysplasia and subluxation of the femoral heads. The stifles appeared normal with

no edema noted. A diagnosis of severe hip dysplasia was made, and the owner was informed that stifle surgery was not needed at this time. It was recommended that she consult with an orthopedic specialist regarding surgery for hip dysplasia. The canine emergency form that Ms. Hart refers to in her complaint was not for an emergency for her dog, but rather a standard form of emergency anesthesia drugs that we print for all surgery patients and is included with your copy of the records.

On February 2, no examination was made of Karma as Ms. Hart describes. Rather the record indicates that she had called our office and asked if we were able to provide after care for hip dysplasia. Our answer was yes, that we were able to perform physical therapy, and she had indicated her thanks. Again, no physical contact was made with Karma at that time.

Karma was brought to me on February 27 for a recheck after her surgery in California. Her incision had healed well. There was moderate restriction in her range of motion and I encouraged Ms. Hart to perform range-of-motion exercises on Karma daily. There was no request for post-operative care from Ms. Hart. This is the day that Ms. Hart claims there was mopping activity and Karma fell on the floor. I have included a copy of the security camera footage for the hour surrounding her visit. As can be seen, there was no mopping activity during that time. I did not note any sutures present during that visit as apparently the sutures had turned completely transparent and were not easily visible without a surgery light. I assumed that Karma had chewed her stitches out.

The next appointment with Karma was made March 1, 2018. Again, a Thursday during which I was not in the office. It is noted in the medical record that our assistant Zach removed the sutures after having to utilize a surgical light. A radiograph was made at that time. Ms. Hart was originally charged for two views, even though only one radiograph was made. She was then refunded for one radiograph, but then subsequently it was decided to not charge her for the radiograph at all due to her complaint of this being a result of the fall.

I took a phone call from Ms. Hart on March 2, 2018 in which she complained about the mopping and Karma's fall and felt us to be responsible. This is when I checked the security cameras and saved the copy. Ms. Hart also mentioned that she was in contact with Karma's surgeon in California and that they were going to follow up on the injury with her.

The next time I saw Ms. Hart and Karma was March 27, 2018 when she indicated that Karma was not doing better and that Ms. Hart had been trying to rehabilitate Karma and Karma got worse. Ms. Hart did mention that she was allowing Karma to run outside despite her mention of resting Karma. During the examination I found there to be right pelvic limb lameness and 50% reduction in range of motion of the right hip. Ms. Hart had admitted to allowing Karma to run and jump and not being able to complete physical therapy. I informed her that physical therapy would be essential for this surgery to heal and cautioned her that without physical therapy, Karma's surgery would not have a favorable outcome. We

refilled Karma's Tramadol for pain, but there was no appointment made for physical therapy at that time. I have no recollection of the cats in the display area of the waiting room, but we would typically not display unhealthy animals for adoption in the waiting room.

On April 4, Karma presented to us for physical therapy and I prescribed heat therapy for 5-10 minutes prior to range-of-motion exercises, followed by cold therapy for 5-10 minutes each visit. Ms. Hart also makes mention of our security cameras having been moved. This is false. Our security cameras have not been moved since they were installed.

On April 6, Ms. Hart makes complaint of an employee using Lysol outside of the exam room and Karma almost falling. This was in the late afternoon and our maintenance personnel go home at 2:00 and so there would not typically be anyone cleaning the door handle at that time. Our security cameras only go back a month. Since I just discovered this complaint we were not able to check the camera.

Ms. Hart makes several mentions of Karma's physical therapy appointments being canceled. The cancellations were at Ms. Hart's request.

I rechecked Karma's range of motion on April 25, 2018. She had complete range of motion at that time, although there was some reluctance. There was no lameness noted initially, but after extension there was mild lameness. Ms. Hart requested to decrease physical therapy to twice per week instead of the three times per week that was initially prescribed and so I recommended that she perform at least one physical therapy at home in that case.

On May 5, 2018, Ms. Hart makes complaint of a Jesse (there is no one named Jesse in our employ) giving a vaccine in Karma's hip. In actuality, it was Zack that gave DA2PP subcutaneously over the left hip.

We have no record of any appointments made after May 5, 2018.

As to Ms. Hart's statement of removing the last remaining stitch in April 2018, my suspicion would be that she removed the subcutaneous knot at the proximal end of the suture line which frequently works its way to the surface of the skin.

As to her statement of our records showing inconsistencies regarding dates, weight, medications dispensed, and feeding information, I can only assume that she is having difficulty interpreting the printout of the records that we sent to her. As every time there is a change made to the record, a date is reflected with it and the weight history is taken on a scale and recorded in the record. Any errors in feeding information would be due to misinterpretation during history taking. She states that there was a "canine emergency" on the record. The "canine emergency" that she is referring to is the emergency anesthesia drugs form that is printed for every surgery we do.

In conclusion, I am concerned about the veracity of Ms. Hart's statements which were documented false on at least one occasion with video recording, the lack of cohesiveness to her statements, and her lack of a clear complaint. I hope you found this narrative helpful, and if you have any question please do not hesitate to contact me.

Sincerely,

William R. Dean

William R. Dean, DVM
Business Owner
North Valley Pet Hospital

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
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VETBOARD.AZ.GOV

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Donald Noah, D.V.M. - Chair
Amrit Rai, D.V.M.
Adam Almaraz - ***Absent***
Christine Butkiewicz, D.V.M.
William Hamilton

STAFF PRESENT: Tracy A. Riendeau, CVT, Investigations
Michael Raine, Assistant Attorney General

RE: Case: 19-03
Complainant(s): Mariella Hart
Respondent(s): William Dean, DVM (License: 4263)

SUMMARY:
Complaint Received at Board Office: 7/13/18
Committee Discussion: 10/2/18
Board IIR: 11/21/18

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow)

On February 2, 2018, "Karma," a 1 ½ year-old female Labrador mix had right sided femoral head and neck excision performed at a specialty center. Respondent provided care for the dog, including exams and physical therapy post-surgery.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Mariella Hart*
- Respondent(s) narrative/medical record: *William Dean, DVM*
- Witness(es) narrative: *North Valley Pet Hospital Staff*

PROPOSED 'FINDINGS of FACT':

1. In November 2017, Respondent's associate suspected ACL issues and recommended Respondent evaluate the dog and possibly perform surgery.

2. On December 5, 2017, Respondent examined the dog to perform possible ACL surgery. It was determined the dog had hip dysplasia and consultation with an orthopedic specialist was recommended.

3. On February 7, 2018, the dog underwent surgery on the right hip at a specialty facility in California.

4. On February 27, 2018, the dog was presented to Respondent for exam post-surgery. The dog was examined, the incision had healed well and there was a moderate restriction in the range of extension – Respondent encouraged Range-of-Motion exercises. The dog was vaccinated and discharged.

5. At this visit, Complainant claimed staff had mopped the floor which caused the dog to fall on the floor. Additionally, Respondent did not see any sutures in the incision at that time and suspected the dog chewed them out. It turned out the sutures turned transparent and could not be seen without a surgical light.

6. On March 1, 2018, the dog was presented to Respondent's premise for suture removal. Staff removed the stitches. Respondent's associate performed radiographs of the dog as Complainant was concerned the dog slipped and fell last visit. Tramadol was refilled and the dog was discharged.

7. On March 2, 2018, Respondent spoke with Complainant regarding her complaint that the dog fell as a result of staff mopping. She felt the dog had a setback due to the fall and did not feel she should be charged for radiographs. Respondent agreed to refund the cost of the radiograph and recommended using a body sling with the dog in the future. The security cameras were checked and no mopping of the floor had occurred during the time Complainant was in the building.

8. On March 27, 2018, the dog was presented to Respondent for a recheck. Complainant did not feel the dog was improving – she tried rehab and the dog became worse. Respondent examined the dog and noted toe touching lameness in the right pelvic limb and 50% range of motion restriction in the right hip. Complainant admitted to allowing the dog to run and jump. Respondent advised that physical therapy was essential for the surgery to heal. Tramadol was refilled and the dog was discharged.

9. In April 2018, the dog was presented to Respondent's premise 5 times for physical therapy.

10. On April 6, 2018, Complainant stated that staff used Lysol outside the exam room and the dog almost fell. Respondent stated that maintenance personnel leave at 2:00pm, and Complainant's appointment was in the late afternoon.

11. On April 25, 2018, Respondent evaluated the dog and she had a complete range of motion at that time. There was no lameness noted initially but after extension there was mild lameness. Complainant requested to decrease physical therapy to twice per week instead of three therefore Respondent recommended Complainant perform at least one physical therapy at home.

12. On May 5, 2018, the dog was presented for physical therapy. At this visit, the dog was administered DA2PP by staff. No exam was noted. Metacam was refilled and the dog was discharged.

13. On June 13, 2018, Respondent picked up a copy of the dog's medical records.

14. On June 20, 2018, Complainant stated that she had made an appointment for blood work and when she arrived at the premise, she was told that she did not have an appointment but one could be scheduled. No appointment was made.

15. Complainant stated that she had to remove the last stitch that was left in the dog's incision that was missed by Respondent's staff. Respondent stated that he suspected Complainant removed the subcutaneous knot at the proximal end of the suture line which frequently works its way to the surface of the skin.

16. Complainant further expressed concerns that the medical records she received showed inconsistences regarding dates, weight, medications dispensed and feeding information. Respondent felt Complainant had difficulty in interpreting the information in the medical records.

COMMITTEE DISCUSSION:

The Committee discussed that they were unclear what Complainant's concerns were. She was satisfied with the medical care that was provided by Respondent – he identified that the dog's issues were not related to a ruptured ACL. There were no issues with the physical therapy that was performed to the dog.

There was visual evidence that no mopping had occurred that Complainant believed led to the dog falling and injuring itself. The crash sheet in the medical record that Complainant had concerns with was likely a document generated by the practice software in case there was an emergency with the dog to avoid having to do calculations during a crisis event. The dog did not need resuscitation.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

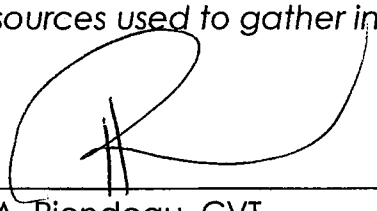
COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 1, with Mr. Almaraz absent.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division